Pediatric Sports and Spine Associates

PATIENT HISTORY FORM

This is a confidential record and information contained here will not be released without your consent.

Today's Date: ___/___/_____ Date of Injury: __/__/____ Date of Birth: __/__/_____

Last Name: _____ First Name: _____ Middle: _____

Primary Care Physician: _____ Who referred you to us? _____

Do you want a report sent to this physician? _____ yes _____ no

CHIEF COMPLAINT: What is the main reason for your visit today? Describe problem in detail. (What Hurts).

_____

Sports related? _____ Motor Vehicle Accident? _____

Full term pregnancy? _____ Normal Birth? _____ Complications/Developmental Delays? _____

If premature was patient in NICU? _____ Age when walked? _____

How did you hurt yourself? _____

What makes the problem worse? _____ Better?_____

How long does the problem usually last? Constant: _____ Occasional: _____

Does the pain interfere with your normal functions? (Explain) _____

Have you seen another physician for this problem? (Explain) _____

Have you had any diagnostic studies or treatments for this problem? (X-rays, MRI, EMG, Bone Scan, Bone Density)

If so, when and where? _____

Pain Level _____ 0-3 (mild) _____ 4-6 (moderate) _____ 7-10 (severe)

List any changes in medical history in the last 6 months (**DIAGNOSIS, MEDICINES, or SURGERIES**):

Medications: _____ Surgeries: _____

List all known drug allergies: _____

Height: _____ Weight: _____

Female Patients:

Age when menses began: _____ (month/year) Regular or Irregular: _____

Guardian Signature: _____

Provider Signature: _____